

REHABILITATION SERVICES PLAN

**USER GUIDE FOR THE
PRIORITY RATING SCALE**

New  Brunswick

**Health and
Community Services**

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1.0 Introduction

1.1 Purpose [Why was the PRS developed?]

The Priority Rating Scale (PRS) is a tool for the consistent prioritization of individuals requiring rehabilitation services. Rehabilitation services in this context include those services provided by audiologists, occupational therapists, physiotherapists and speech language pathologists. **The PRS will help determine which individuals have a greater need for rehabilitation service relative to other individuals.** The consistent application of the priority factors contained within the PRS will help ensure equitable access to rehabilitation services for all New Brunswickers. The PRS will:

- enhance accountability
- increase objectivity
- support professional decision making
- promote consistency

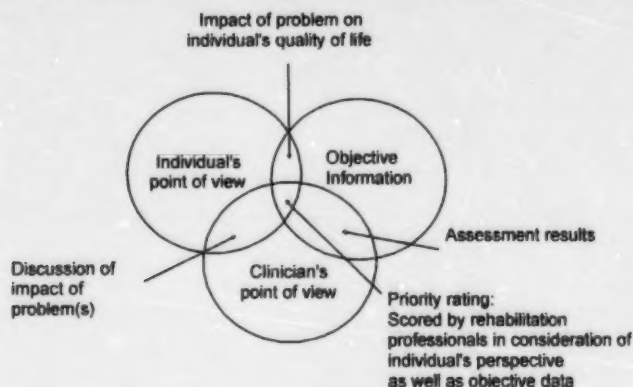
1.2 Conceptual Framework [What does the PRS measure?]

The Priority Rating Scale measures the relative need of an individual who requires rehabilitation services. The PRS is derived from a priority setting framework which attempts to determine the relative need of an individual by measuring indicators such as 1) the impact of the primary presenting problem on function; 2) the predicted outcome of the rehabilitation intervention and 3) the impact of service delay. The thirty-two rehabilitation professionals who participated in the development of the PRS judged these indicators of need to be important, measurable, broad based, defensible and client centred.

The priority setting framework is built upon a client centred approach. The total score on the PRS reflects a combined perspective including: the individual's point of view, the clinician's point of view and objective information. The diagram on the next page illustrates how the priority rating is a reflection of all three perspectives.

1.0 Introduction

Figure 1: Elements Incorporated into the Priority Rating Process



Note: Diagram taken from the Alberta Health document titled: A Priority Setting Framework for Community Rehabilitation Programs in Alberta Regional Health Authorities.

1.3 Integration With Other Priority Initiatives In N.B.

Speech-Language Pathology (SLP): In 1994, the Family and Community Social Services Division of the DHCS released *Preferred Practices: Speech Language Pathology Services/Support Services to Education and Community Based Services for Children with Special Needs*. *Preferred Practices*, developed by an inter-departmental committee, includes a tool to guide speech language pathology caseload selection using the following criteria: 1) communicative competence; 2) prognosis and 3) partnership/support. These criteria have been considered by speech language pathologists during the discipline specific validation process for the PRS.

1.4 Population Receiving Rehabilitation Services

The PRS will apply to a broad range of individuals who have been identified as having a need for rehabilitation service. The PRS will be completed by the following rehabilitation professional groups: AUD, OT, PT and SLP. The PRS applies to individual requests for rehabilitation services directed to the Extra-Mural Program Community Rehabilitation Pool and Outpatient Rehabilitation Services. Requests which are not specific to an individual will be managed separately. (See Rehabilitation Service Delivery Guidelines September 1997)

1.0 Introduction

1.5 Validity of the PRS

The New Brunswick version of the Priority Rating Scale, as it exists in the "A Guide to Accessing Rehabilitation Services," was developed in 1995/96 by a Working Committee composed of representatives of the Department of Health & Community Services, rehabilitation professionals and other stakeholders. The current version of the Priority Rating Scale contains three priority factors which are: 1) Impact of Primary Presenting Problem; 2) Predicted Outcome of the Intervention; and 3) Impact of Service Delay [see Appendix A].

As with any new instrument, a process to establish reliability and validity has to be initiated. The diagram below illustrates the steps required to establish a reliable and valid instrument.

PRS Validation Process

Validity:

How well a scale measures what it is intended to measure



To date, the priority factors contained within the PRS have evidenced an acceptable level of content and face validity. The next section describes the processes used to establish validity.

1.0 Introduction

1.5.1 Process to Establish Content Validity of the PRS

Discipline specification process: The version of the PRS contained within this document has been enhanced through the participation of thirty-two rehabilitation professionals representing all eight Hospital Corporations in the province. **Members of the discipline specific work groups** participated in a series of consensus building sessions. This began with brainstorming an appropriate pool of priority factors to be considered in determining an individual's relative need for rehabilitation service. Following this step, the discipline specific work group participants applied item selection criteria to reduce the pool of factors to a smaller set. [See Item Selection Criteria for the PRS in Appendix B]. Once a draft version of the PRS was prepared, the discipline specific work group participants added discipline specific content to enhance the definitions and examples contained within the instruction guide for using the PRS. The discipline specific work group participants also reviewed the appropriateness of the scoring methodology for the PRS. (Note: Members of the Discipline Specific Work Groups are listed in Appendix C.)

1.5.2 Process to Establish Face Validity of the PRS

Rehabilitation professionals from across the province were recruited to participate in the PRS Field Study [see Appendix D]. One of the goals of the Field Study was to measure the face validity of the PRS. Based on written feedback, participants agreed that the PRS score accurately represented the current level of relative need of the broad range of clients that were included in the study.

The development of the PRS has been a participatory process to date and will continue to involve rehabilitation professionals as the validation process continues. Section 6.0 in this Guide outlines the ongoing validation process for the PRS.

1.6 Additional Information Regarding the PRS

See Appendix E for additional information concerning the use of the PRS.

2.0 Defining The Primary Presenting Problem

The first step in the completion of the PRS is the determination of the primary presenting problem. The primary presenting problem describes the individual's *current* inability to function. As well, it can describe the individual's *potential* inability to function, in a specific area, for up to twelve months.

2.1 What Does "Primary" Mean?

It is understood that many individuals may present with multiple needs for rehabilitation service which could require multiple intervention approaches. In these cases, the rehabilitation professional must focus specifically on the following for the purpose of scoring the PRS: 1) the individual's **primary** concern; 2) the **primary** area of functional impact and 3) the **primary** anticipated goal of the intervention. The PRS score is based jointly on the primary concern, primary area of functional impact and primary anticipated goal of the intervention. The rehabilitation professional will consider **only** the primary presenting or potential problem in determining the individual's level of need. Other problems may exist for an individual, however, the PRS score is based on only one presenting or potential problem. This does not restrict the rehabilitation professional from developing secondary goals addressing other needs during intervention.

An example may help to illustrate the importance of defining the primary presenting problem. A child with a developmental delay has been referred to SLP due to difficulty swallowing and communicating with other children. The primary or first intervention will most likely focus on swallowing since this is a life sustaining activity which requires immediate care.

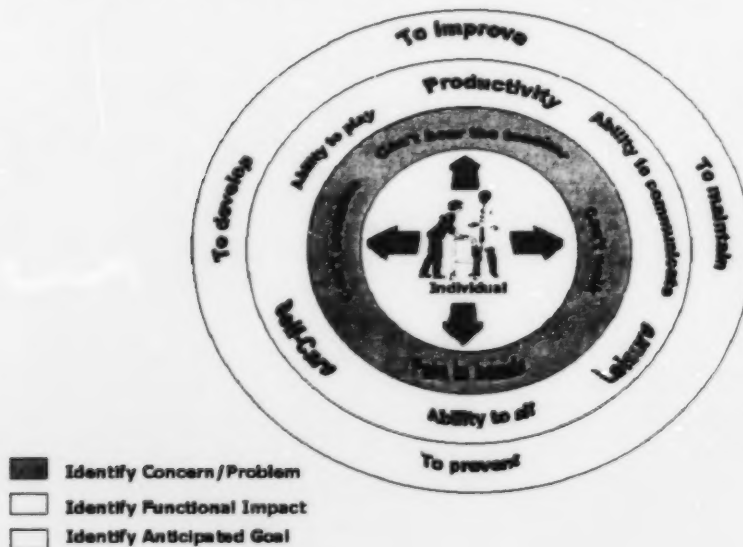
Some cases may not be so clear. Some requests for speech language pathology may involve multiple aspects of communicative function. In some situations, there may be two areas which appear to impact equally on function, such as "speech" (articulation, phonology) and "language". If **both areas impact equally and both areas will be addressed by the intervention**, it may be appropriate and reasonable to consider these aspects together as the primary presenting problem.

2.0 Defining The Primary Presenting Problem

For example, a child presents with problems related to both phonology and language. In this case, the intervention will be provided to "facilitate the development of intelligible two word utterances in the context of daily routines". Both the "speech" and "language" aspects are addressed. The presenting problem can be summarized as "child cannot express basic needs and wants". In the situation where only "speech" is affected or "speech" is clearly the primary presenting problem, it could be described as "child cannot produce intelligible speech". If "language" alone is affected, or "language" is clearly the primary presenting problem, the presenting problem could be described as "child cannot produce simple sentence structures / word combinations."

2.2 The Step By Step Approach to Defining the Primary Presenting Problem

This section of the Guide will outline the steps in defining the primary presenting problem. The image below illustrates the steps for defining the primary presenting problem. The process begins in the center of the circle with the individual's primary concern/problem.



2.0 Defining The Primary Presenting Problem

STEP 1 - Identifying the Specific Concern/Problem: (Individual's description of concern/problem)

The first step in defining the primary presenting problem is to record the individual's *specific concern or problem which led the individual to seek assistance from your discipline*. A concern or problem could range from "pain in my hands" to "unable to keep my balance" to "my baby doesn't seem to hear." **Note that "individual" is defined to include consideration of caregiver/teacher and/or family in all contexts.**

STEP 2 - Linking the Concern/Problem to Impact on Function: (Impact on the individual's ability to.....)

The second step in defining the primary presenting problem is to link the individual's concern/problem to a specific area of function. The concern can be linked to the individual's functional ability or capacity to perform the activities necessary to realize aspirations, satisfy needs and to change or cope with the environment. The description of the individual's ability to function can be derived from a combination of three sources: 1-information taken from the individual's point of view; 2- clinician's judgement and 3- objective information from secondary sources. Once the concern is expressed in terms of the individual's ability to function in a specific area, the goals or the approach to rehabilitation intervention can then be considered.

STEP 3 - Linking Impact on Function to the Primary Anticipated Intervention Approach: (Improve individual's ability to...)

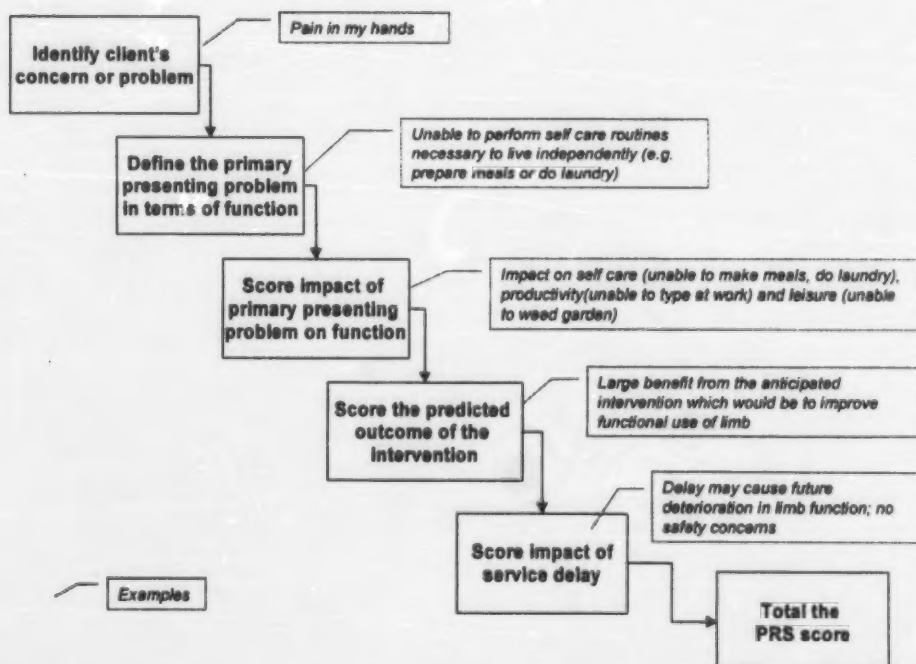
Now that the impact on the area of function or potential function has been identified, the rehabilitation professional needs to determine the target of the anticipated intervention. Is the anticipated intervention approach intended to develop function, improve function, maintain or prevent further deterioration in function or prevent dysfunction? The anticipated intervention approach, once identified, may be useful when rating the second priority factor: the predicted outcome of the **anticipated** intervention.

2.0 Defining The Primary Presenting Problem

2.3 Linking the Primary Presenting Problem to the Total PRS Score

Once the primary presenting problem has been identified, this is recorded on the top section of the PRS [see Appendix A]. This definition of the primary presenting problem must be taken into consideration when rating each of the priority factors. The PRS score is limited to the the primary presenting problem. Rehabilitation professionals, when completing the PRS, should rate only those aspects which specifically relate to the presenting problem. For example, when rating the impact of the primary presenting problem, the rehabilitation professional must consider only those areas of function that are affected by the primary presenting problem as opposed to all areas of function. When rating predicted outcome, the rehabilitation professional must consider the potential outcome of the anticipated rehabilitation intervention for the specific primary problem. When rating impact of service delay, the rehabilitation professional must rate the impact of service delay on the specific primary presenting problem.

The diagram below illustrates the overall step by step process used to score the Priority Rating Scale (PRS).



2.0 Defining The Primary Presenting Problem

2.4 Discipline Specific Examples of the Primary Presenting Problem

Examples of the primary presenting problem are illustrated below for each of the rehabilitation disciplines. The anticipated intervention is recorded in the chart below. This is done to illustrate the link between the primary presenting problem and the predicted outcome of the intervention. The diagnosis is recorded below to illustrate that the diagnosis alone does not adequately describe the primary presenting problem in functional terms.

Primary Presenting Problem - Audiology

	Client's Concern	Primary Presenting Problem (Impact on Function)	Anticipated Intervention (To develop, improve, maintain, prevent dysfunction)	Diagnosis
Infant	My baby does not respond to sound/noise	Unable to detect sound	1) provide appropriate amplification if required 2) introduce aural rehabilitation 3) develop remedial plan	Sensorineural hearing impairment
Child	My child does not hear very well in group activities	Unable to select, recognize and attend to speech in order to succeed at school	1) make appropriate referrals 2) inform teacher of compensation strategies 3) provide FM system if needed	Bilateral conductive hearing impairment
Adult	I can't hear very well especially when people are talking around me	Unable to discriminate speech in the presence of background noise	1) recommend amplification 2) provide environmental modifications 3) provide communication and coping strategies	Mild sensorineural hearing impairment
Senior	My husband can't communicate very well when we talk and he doesn't want to get a hearing aid	Unable to interact with peers and caregivers	Provide coping strategies to caregivers and individual for implementation in client's environment	Moderate sensorineural hearing impairment

2.0 Defining The Primary Presenting Problem

Primary Presenting Problem - Occupational Therapy

	Client's Concern	Primary Presenting Problem (Impact on Function)	Anticipated Intervention (To develop, improve, maintain, prevent dysfunction)	Diagnosis
Infant	I have difficulty carrying my baby	Unable to bond Unable to feed the baby	1) Education regarding appropriate carrying and holding 2) Facilitation of developmental milestones and quality posture/movement	Cerebral Palsy
Child	My child cannot print like his classmates	Unable to function at the level necessary for success in the classroom	1) Remedial strategies to develop fine motor skills 2) Compensatory strategies to facilitate performance in class 3) Consultation with teacher	Developmental Coordination Disorder
Adult	I cannot make meals at home	Unable to perform self care routines necessary to live independently	1) Develop functional use of involved limb 2) Teach compensatory strategies 3) Modification of environment 4) Provision of adaptive aids/equipment 5) Obtain home support	CVA
Senior	I cannot keep my client positioned safely in his wheelchair	Unable to engage in daily activities	1) Education regarding appropriate positioning 2) recommendation of appropriate seating and positioning equipment 3) Follow-up after equipment is obtained	Multiple sclerosis

2.0 Defining The Primary Presenting Problem

Primary Presenting Problem - Physiotherapy

	Client's Concern	Primary Presenting Problem (Impact on Function)	Anticipated Intervention (To develop, improve, maintain, prevent dysfunction)	Diagnosis
Infant	My 16 month old child can't crawl, roll or sit up to play with toys	Unable to explore environment; unable to promote proper motor development	1)Introduction of controlled movements and positions to reduce spasticity 2)Consultation with parents to maintain proper positioning	spastic quadraplegia
Child	My child has difficulty participating in school activities	Unable to participate in gym class at school and is often being left out	1)Consultation with the physical education teacher to adapt certain activities of the curriculum for this client 2) Teach specific exercises as needed to build client's endurance and improve sitting balance	mild cerebral palsy
Adult	I am not coping well at home	Unable to perform domestic chores of household	1)Active treatment 3 times per week aimed at decreasing pain and increasing mobility and function	post mastectomy
Senior (client in nursing home)	My client has fallen twice and is unsteady when getting in and out of bed or chair	Unable to transfer independently	1)Consultation with nursing home staff to determine their particular needs in assisting client 2)Instruction to client and staff re: safe transfer techniques 3)Instruction to client re: series of balancing and strengthening exercises	incomplete quadriplegia and early dementia

2.0 Defining The Primary Presenting Problem

Primary Presenting Problem - Speech Language Pathology

	Client's Concern	Primary Presenting Problem (Impact on Function)	Anticipated Intervention (To develop, improve, maintain, prevent dysfunction)	Diagnosis
Infant	My baby is having trouble nursing	Unable to achieve closure on nipple / cannot suck or nurse	Consultation with caregiver to improve oral intake and development of oral motor skills through modified/ appropriate feeding strategies	Bilateral cleft lip and palate
Pre-school Child	My 3 year old son keeps using gestures and sounds	Unable to express basic needs, wants	1) Introduce alternative communication 2) Facilitate speech sound production 3) Develop single word use and functional two word combinations	Delayed language/speech development
Student (Grade 1)	My child uses only single words to communicate	Unable to socialize, interact with peers or express self in class	1) Develop functional two word combinations 2) Consultation with caregivers to promote opportunities for functional communication	Delayed language development
Adult	My husband cannot speak clearly after his stroke	Unable to express needs or wants	1) Provide alternative communication system 2) Improve oral motor functioning/speech sound production	Dysarthria post-stroke
Senior in nursing home	My client keeps choking during meals	Unable to manage solid foods; nutritional status at risk	Modification of eating patterns/ oral intake/food management strategies	Dysphagia due to ALS

3.0 Priority Factor Definitions and Discipline Specific Examples

3.1 Impact of Primary Presenting Problem

The first priority factor involves rating the functional impact or effect of the individual's primary presenting/potential problem on the individual's life. Rehabilitation professionals should consider the impact of the primary presenting problem on: 1) self-care; 2) productivity and 3) leisure. The following definitions are taken from the Occupational Therapy Guidelines for Client Centred Practice, CAOT, 1991.

3.1.1 Self-care:

[What People Do To Look After Themselves]

Self-care refers to daily living skills including those personal activities an individual performs to prepare for and maintain a daily routine. It refers to activities that individuals initiate and perform on their own behalf in the interest of maintaining life, healthful functioning, continuing personal development and well-being. This area can also include activities which are essential to personal care and household management. These activities include but are not exclusive to: grooming, hygiene, toileting, feeding, dressing, mobility, bathing, driving, community living (e.g., shopping, banking, transportation).

- ▶ Personal Care (e.g. dressing, bathing, feeding, hygiene, sleeping)
- ▶ Mobility/positioning (e.g. transfers, indoor, outdoor)
- ▶ Functional Communication (receptive/expressive; responsiveness)
- ▶ Household Management (e.g. transportation, shopping, finances)
- ▶ Environmental management (ability to control and respond to environment)

Discipline Specific Examples for Self-Care

AUD: An adult with hearing impairment is unable to communicate in stores, banks etc.

An infant with sensorineural hearing impairment does not respond to sound/noise

3.0 Priority Factor Definitions Specific Examples

OT: A senior, recently diagnosed with early Alzheimer's, is unable to manage independently at home

A 12 year old is unable to transfer from her wheelchair to the toilet at her new school because of the bathroom layout

PT: A senior with shoulder tendinitis for the past 7 months is having difficulty washing, getting dressed and doing housework

A 58 year old woman just had a hip replacement and is unable to bathe in her bathtub

SLP: A 55 year old who has experienced a stroke is unable to communicate his needs while shopping and banking

An infant with bilateral cleft lip and palate is unable to nurse

3.1.2 Productivity: [How People Contribute To Society]

Productivity includes skills and performance in purposeful and productive activities in the home, in employment, in school or in the community. It refers to those activities which enable the individual to provide support to self, family and society through the production of goods and services. It also includes those activities which give meaning and purpose to life. For children, meaning and purpose come from school and play. Adults may find meaning through work (paid or unpaid), or volunteer activities. Productivity activities include play (for children), schoolwork, paid work, volunteer work and homemaking.

- Paid/Unpaid work (e.g. finding/keeping a job, child care, volunteering)
- Play/School (e.g. play skills, educational and pre-vocational activities, homework)
- Experience of self-worth

3.0 Priority Factor Definitions and Discipline Specific Examples

Discipline Specific Examples for Productivity

AUD: A child with hearing impairment is unable to participate in Story Hour at the library.

A 35 year old teacher is experiencing gradual hearing loss and she is unable to discriminate speech with background noise in her classroom

OT: A child with spastic cerebral palsy is unable to manipulate toys in order to play.

A 67 year old woman, recovering from an acute exacerbation of rheumatoid arthritis, is experiencing difficulty returning to her volunteer work with the hospital auxiliary

PT: A 35 year old woman with multiple sclerosis is unable to coordinate upper limbs and has balance and coordination problems. She is unable to continue employment in her profession (law clerk) which requires upper limb coordination

A 9 year old boy with decreased balance is unable to participate in physical education classes at school

SLP: A Grade 1 student who has language comprehension problems is unable to follow her teacher's directions

A call centre operator is experiencing voice problems which cause him to be absent from work

3.1.3 Leisure: [How People Enjoy Life]

Leisure is defined as activities that represent individual interests and preferences. It includes choosing, performing and engaging in activities for amusement, relaxation, enjoyment and/or for self expression. Leisure refers to components of life free from work and self care activities.

These activities includes hobbies, use of free time, cultural interests, recreation, sports, clubs, groups, entertainment,

3.0 Priority Factor Definitions

Specific Examples

socialization, creative activities and games. For children, leisure activities may be similar to play activities except that these activities represent individual interests and preferences.

- Quiet recreation (e.g. hobbies, crafts, reading)
- Active recreation (e.g. sports, outings, travel, gardening)
- Socialization (e.g. visiting, phone calls, parties, group singing, card games, correspondence)

Discipline Specific Examples for Leisure

AUD: An adult with hearing impairment has withdrawn from social interaction due to limited communication abilities (e.g., unable to hear music; unable to use the telephone)

A 4 year old with a hearing impairment is ignored by the other children during play because he cannot communicate or socialize with them

OT: An adult with low vision is unable to engage in her usual leisure pursuits of reading and playing bridge.

A senior with hemiparesis is unable to plant his usual garden plot.

PT: A young girl is unable to play hockey for weeks due to a third degree sprained ankle

A 8 year old girl with spina bifida is unable to master swimming, a favorite family activity

SLP: A 50 year old woman is unable to participate in choir practice because she had a laryngectomy

A 65 year old who has experienced a stroke is embarrassed to go to the restaurant or see friends because she cannot communicate easily with them

3.0 Priority Factor Definitions and Discipline Specific Examples

3.2 Predicted Outcome of The Intervention

The second priority factor is the predicted outcome of the anticipated intervention relative to the primary presenting/potential problem. Rehabilitation professionals are to rate the individual's potential for benefit from rehabilitation service considering the following sub-factors:

- history and success of previous interventions (if any)
- previous assessment results (if available) from observations or other sources (e.g. school files, hospital charts etc.)
- length of time since onset of the presenting problem
- stage in the disease process (if applicable)
- research evidence (see Section 4.4.1)
- overall health condition (see Section 4.4.2)
- other health related or "at risk" behaviours (e.g. typing all day without taking breaks)

It is important to note that some of the sub-factors listed above will not be relevant to every client. Rehabilitation professionals are asked to rate this factor based on the items that are appropriate for the specific client. An additional explanation of two subfactors is provided below.

3.2.1 Research Evidence

Research evidence refers to the extent to which scientific evidence supports the premise that a specific approach to rehabilitation intervention can make a difference to the presenting problem. Unfortunately, information needed is presently not available in a format conducive to the accurate rating of this sub-factor. Extensive literature searches and studies are required to evaluate the outcomes of many rehabilitation interventions. In New Brunswick, work is beginning in areas such as the development of practice guidelines and standard outcome measures which will contribute to the knowledge base in this area.

While this work continues, it is possible that some rehabilitation professionals in specific areas will have the literature findings to support their rating on this sub-factor. This would include published articles, documented research findings and other substantiated reports of outcomes.

3.0 Priority Factor Definitions Specific Examples

3.2.2 Overall Health Condition

Overall health condition refers to:

Any or all physical or cognitive condition(s) which may delay, interrupt or compromise the client's potential to benefit from rehabilitation services

OR

Any or all physical or cognitive condition(s) which may support or enhance the client's potential to benefit from rehabilitation services

Discipline Specific Examples of Predicted Outcome of the Intervention

AUD: An elderly man has successfully been wearing a hearing aid for several years now and recently does not appear to hear as well as before

Increasing dementia may impact a senior's ability to deal with amplification

OT: A child with JRA experiencing an acute exacerbation

An adult requiring palliative care is experiencing discomfort and pain due to positioning in bed

PT: A 70 year old male has suffered from lumbar back pain for more than 15 years. The pain comes and goes. For the past week, there has been exacerbation of the pain and the client has difficulty getting up, sitting or standing for a lengthy period.

A 24 year old male had knee surgery. Client history includes regular aerobic exercise routine and well developed muscle tone

3.0 Priority Factor Definitions and Discipline Specific Examples

SLP: A 32 year old who stutters has successfully completed several intensive fluency programs in the past but is not able to maintain fluency

A person who has recently experienced a stroke has Alzheimer's disease and was not very communicative before the stroke

3.3 Impact of Service Delay

The impact of service delay requires consideration of three factors: physical safety, ability to maximize function and future deterioration in function. Each sub-factor is defined below with discipline specific examples.

3.3.1 Physical Safety

This sub-factor refers to potential situations which may cause danger, injury or death to the individual.

Rehabilitation professionals are asked to consider the impact of a delay in service on the physical safety of the individual and/or caregiver.

Discipline Specific Examples of Physical Safety

AUD: An adult with vertigo (retrochochlear involvement) is unable to drive safely

A child with hearing loss cannot detect oncoming traffic

OT: An elderly woman is at risk of falling due to environmental hazards in her home.

A 12 month old with low tone and delayed developmental milestones requires adaptive equipment in order to be fed and bathed safely.

3.0 Priority Factor Definitions Specific Examples

PT: A client does not know how to use a mobility aide correctly and is at risk of falling

An 12 year old girl with severe CP and chronic chest condition cannot clear her chest secretions

SLP: A 70 year old man with Parkinson's is choking during feedings. He has had two bouts of pneumonia in the past year.

A person who has suffered a right CVA now has difficulty chewing and swallowing which may compromise their nutritional status and put them at risk for aspiration pneumonia

3.3.2 Ability To Maximize Function

This sub-factor refers to the risk of delay to the individual's potential to maximize functional ability considering:

- ▶ critical periods of development
- ▶ critical periods of the disease or recovery process
- ▶ post-injury periods that may affect the individual's ability to function as independently as possible

Rehabilitation professionals are asked to rate the potential impact, if service is delayed, on the individual's potential to maximize functional ability.

3.0 Priority Factor Definitions and Discipline Specific Examples

Discipline Specific Examples of Ability to Maximize Function

AUD: An infant with severe hearing impairment requires intervention to maximize communicative abilities

A senior requires timely identification of hearing loss and hearing aids in order to maximize opportunities for social interaction

OT: An infant who requires early intervention to maximize fine motor development

A senior who is recovering from a C.V.A. requires intervention to facilitate upper extremity function

PT: An adult who sustained a back injury has returned to work without any treatment/education regarding back care. He is currently at risk of re-injury or sustaining a more serious injury due to deconditioned muscles and lack of knowledge of proper body mechanisms.

An infant with torticollis requires intervention to improve head and neck control which will maximize developmental functions such as eating, sitting, playing etc.

SLP: A kindergarten student requires teaching of sound awareness to facilitate reading mastery.

A child with limited language skills requires intervention to acquire pre-reading sound awareness/recognition patterns to increase her chances for academic success

3.3.3 Future Deterioration In Function

This sub-factor refers to the extent to which a delay in service will **negatively** impact the individual's future function considering:

- ▶ conditions which may change over time
- ▶ possible deterioration in the underlying condition
- ▶ potential for developing related problems
- ▶ risk of admission/readmission to hospital
- ▶ risk of having to leave the home (e.g. move to Nursing Home etc.)

3.0 Priority Factor Definitions Specific Examples

Rehabilitation professionals are asked to rate the potential impact of a delay in service on the individual's future deterioration of functional ability.

Discipline Specific Examples of Future Deterioration in Function

AUD: An adult requires assessment to identify an acoustic neuroma may result in permanent physical effects (e.g. decreased hearing followed by decreased communicative ability; facial palsy, hence possible speech/feeding difficulties) etc.

A child with chronic middle ear problems requires intervention to prevent other problems such as decreased hearing; difficulties at school/communicating. If the otitis was not identified and treated, then other conditions may develop (e.g. cholesteatoma; meningitis etc.)

OT: An adult requires burn scar management when the scar is over a joint.

A senior requires proper positioning and seating to prevent skin problems

PT: An adult with Parkinson's has recently fallen and broken a hip. Early mobilization is necessary to prevent any increase in rigidity and to maintain independence in ambulation.

An adult with a shoulder injury is developing edema and trophic changes in hand. Delay of intervention may result in further deterioration of function and secondary circulatory complications.

SLP: An adolescent with a communication disorder is not be able to socialize with peers and is at risk for socially inappropriate behavior and delinquency

A 10 year old client with hoarseness may develop vocal cord pathology leading to the necessity of surgery.

4.0 Guidelines for Collecting Intake Information

The process of collecting information and obtaining responses to questions is referred to as 'Intake.' The following information has been identified as useful for the completion of the PRS. Questions are listed below to facilitate the collection of information to describe the primary presenting problem and the impact of the primary presenting problem. These questions could be used directly with the client or with a third party in an interview format. The empty brackets ()'s signify the name of the client and are used in the questions below.

4.1 Description of the Primary Presenting/Potential Problem

- ▶ Please describe ()'s problem(s)/concern(s).... OR
- ▶ Please describe the problem you would like to prevent

- ▶ Generally, describe how ()'s life has been affected by this problem? OR
- ▶ Generally, describe how ()'s life might be affected by this problem if it developed?

- ▶ In your view, what is the most important problem to focus on?

- ▶ What is ()'s usual role/usual daily activities?

▲ Record the primary presenting problem in the box on the PRS

4.2 Impact of the Primary Presenting/Potential Problem

Please probe for information describing how the primary presenting/potential problem impacts ()'s ability to function by asking the following questions:

- ▶ Has the problem interfered with ()'s ability to ... OR
- ▶ Could the potential problem interfere with ()'s ability to ...
 - dress, bathe, feed, sleep, groom etc.
 - move, transfer indoors/outdoors etc.
 - cope at home
 - communicate/respond, input/output
 - drive car, go shopping, banking etc.
 - control/respond to environment

[see Section 3.0 for more examples]

4.0 Guidelines for Collecting Intake Information

- ▶ Has the problem interfered with ()'s ability to... OR
- ▶ Could the potential problem interfere with ()'s ability to ...
 - work at a job
 - do work around the house
 - go to school*[see Section 3.0 for more examples]*

- ▶ Has the problem interfered with ()'s social activities like... OR
- ▶ Could the potential problem interfere with ()'s social activities like ...
 - visiting with friends
 - phone calls
 - writing cards
 - attending church etc.*[see Section 3.0 for more examples]*

- ▶ Has the problem interfered with ()'s leisure activities like... OR
- ▶ Could the potential problem interfere with ()'s leisure activities like ...
 - gardening
 - sports
 - crafts, hobbies etc.*[see Section 3.0 for more examples]*

The remaining sections list the information which may be required to determine the predicted outcome of the intervention and the impact of service delay. Not all of this information will be available for each client. **The PRS is designed to be completed based on relevant and available information.** It is not expected that every question will be presented and answered.

4.3 Predicted Outcome of the Intervention*

*(*Note: The answers to the questions listed below will likely come from sources other than the client themselves.)*

Has ()'s received any previous rehabilitation intervention for this primary presenting problem?

IF YES: What rehabilitation service was provided? (AUD, OT, PT, SLP)
What was the result/outcome?

4.0 Guidelines for Collecting Intake Information

What were the previous assessment results? (if any are available)

What is the stage of the disease process? (if applicable)

What is the length of time since onset of the primary presenting problem?(if applicable)

What is ()'s overall health condition?

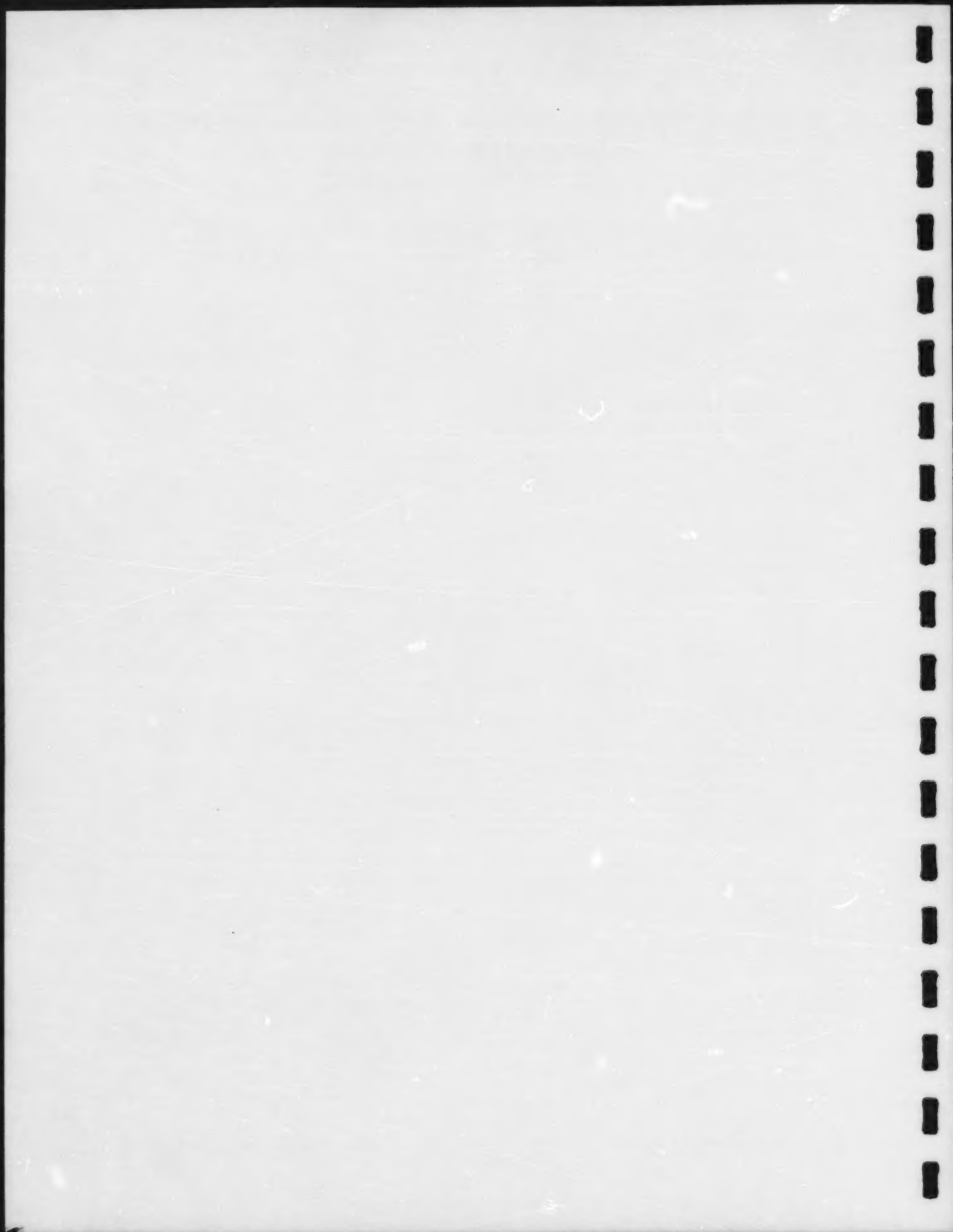
Does () have any other health conditions that may affect the primary presenting/potential problem?

4.4 Impact of Service Delay

If service is delayed, what is the impact on ()'s present and/or future:

- physical safety
- ability to maximize function
- future deterioration in function

How does () currently cope with the primary presenting/potential problem?



5.0 Guidelines for Scoring the PRS

The PRS score reflects the rehabilitation professional's expert opinion of the individual's need for rehabilitation service relative to other clients. The rating is based on information available at the time of completion. The PRS is designed to be completed at the time of intake with or without direct contact with the client. It is recognized that all possible information will not be available at the time of completion. **Rehabilitation professionals will be scoring the PRS based on the information available at the time of completion.**

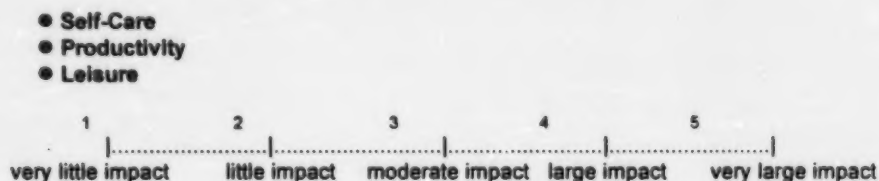
5.1 Impact of Primary Presenting Problem

The rehabilitation professional is asked to rate the global impact of the primary presenting problem on the individual's current ability or future ability to perform activities in any or all of the following three areas:

- self-care
- productivity
- leisure

The rehabilitation professional may project the potential impact of the primary potential problem up to a maximum period of 12 months. As part of the global rating, the rehabilitation professional will also take into consideration the impact of the primary presenting problem on the family or caregiver's performance in **any or all three areas** where appropriate.

This priority factor is scored on a five point scale ranging from "very little impact" to a "very large impact." The rehabilitation professional must circle one number on the rating scale and record that number in the box under the column labelled "priority ratings" [See Appendix A].



5.2 Predicted Outcome of Intervention

The rehabilitation professional is asked to rate the individual's potential for benefit from the specific rehabilitation intervention targeted toward the primary presenting problem. The rehabilitation professional can consider the following factors in determining the potential for benefit from service.

5.0 Guidelines for Scoring the PRS

- ▶ history and success of previous interventions
- ▶ previous assessment results
- ▶ length of time since onset of primary presenting problem
- ▶ stage in disease process
- ▶ research evidence
- ▶ overall health condition
- ▶ other health related or "at risk" behaviors

This priority factor is scored on a five point scale ranging from "very little benefit" to a "very large benefit." The rehabilitation professional must circle one number on the rating scale and record that number in the box under the column labelled "priority ratings." This number will be included in the total score for predicted outcome.

- History and success of previous interventions
- Previous assessment results
- Length of time since onset of primary presenting problem
- Stage in disease process
- Research evidence
- Overall health condition
- Other health related or "at risk" behaviors

1 2 3 4 5
|-----|-----|-----|-----|
very little benefit little benefit moderate benefit large benefit very large benefit

5.3 Impact of Service Delay

The rehabilitation professional is asked to rate the potential impact on the individual if service is delayed. The rehabilitation professional can consider three factors in determining the impact of service delay. These include:

- ▶ the potential impact of service delay considering the individual's physical safety on the day that the PRS is completed
- ▶ the potential impact of service delay on the individual's present ability to maximize function
- ▶ the potential impact of service delay on the individual's future deterioration in function for a period of up to 12 months

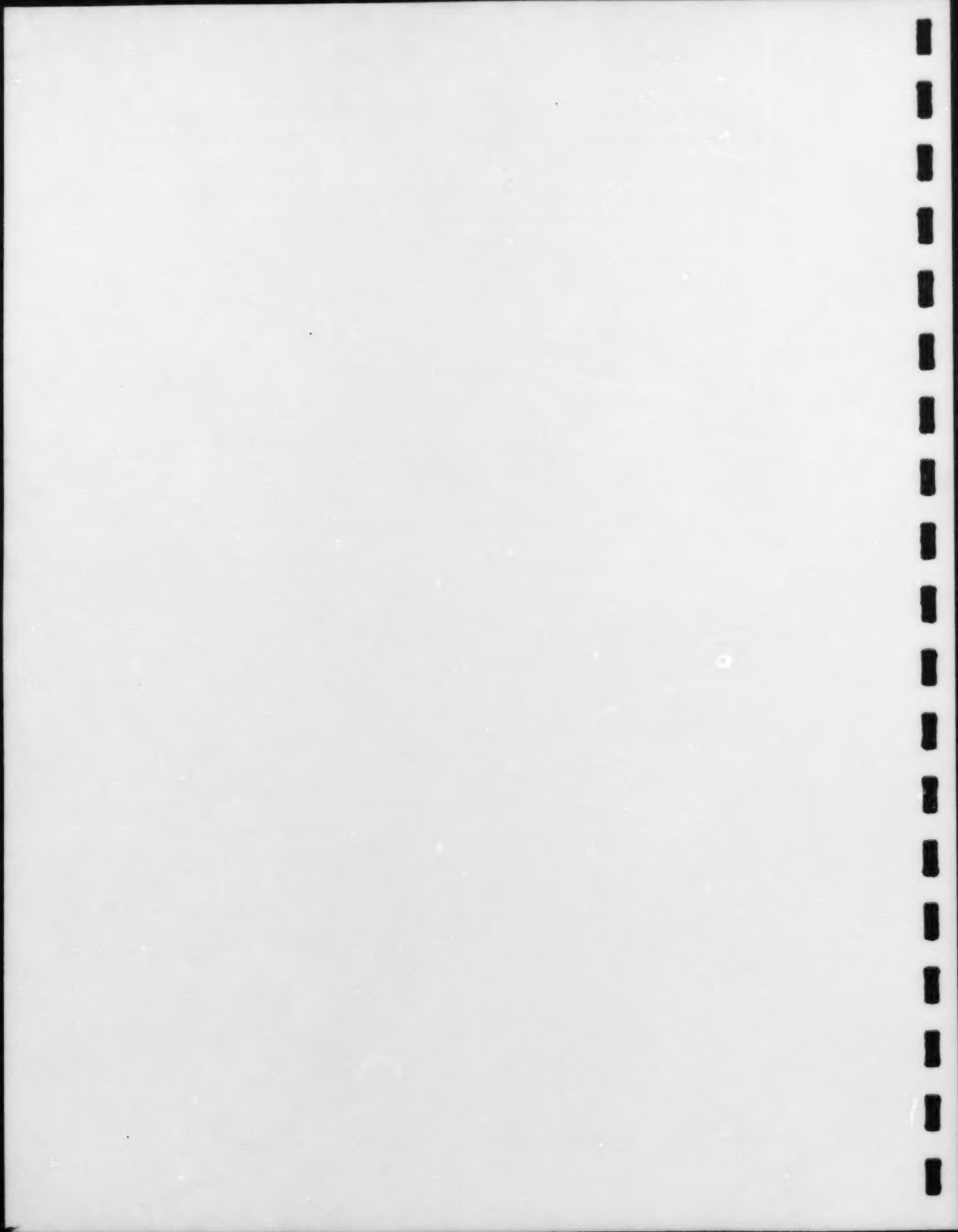
5.0 Guidelines for Scoring the PRS

This priority factor is scored on a five point scale ranging from "very little impact" to a "very large impact." The rehabilitation professional must circle one number on the rating scale and record that number in the box under the column labelled "priority ratings." This number will be included in the total score for impact of service delay.

- Physical safety
- Ability to maximize function
- Future* deterioration in function **Up to a maximum of 12 months*

1	2	3	4	5
.....				
very little impact	little impact	moderate impact	large impact	very large impact

Abbreviated scoring instructions for the PRS appear in Appendix F and can be used to facilitate scoring during the initial implementation of the RSP.



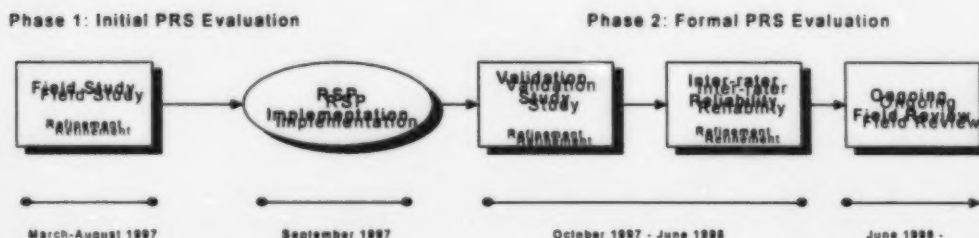
6.0 PRS Validation Process

6.1 PRS Validation Process

As with any new instrument, the validity and reliability of the PRS needs to be evaluated. The validation process can be divided into two phases:

1) the initial evaluation of the PRS which will occur prior to implementation; and 2) the formal evaluation of the PRS which will occur after implementation. The PRS Validation Process is illustrated below.

Proposed Validation Study for the Priority Rating Scale



6.1.1 Initial Evaluation of the PRS

According to Norbeck (1985), "If an instrument lacks content validity, it is pointless to establish its reliability." Therefore, the first step in the validation process of the PRS is to focus on systematically quantifying the content validity of the instrument. An acceptable level of content validity was achieved prior to the implementation of the Rehabilitation Services Plan through the efforts of the Discipline Specific Work Group [see Appendix C for the list of participants]. An acceptable level of face validity was achieved in the field study which occurred in May of 1997. Recommendations from the Field Study participants have been incorporated into the current version of the PRS [Field Study participants are listed in Appendix D]

6.0 PRS VALIDATION PROCESS

6.1.2 Validation of the PRS After Implementation

It is anticipated that the PRS will adequately measure relative need for the majority of clients based on the results of the Field Study where all sectors and all client groups were represented. Rehabilitation professionals will, however, have an opportunity to provide feedback on the validity of the PRS for a period of up to six months after initial implementation of the Rehabilitation Services Plan (November 1997-April 30, 1998). The PRS Validation Form can be used as soon as PRS training is completed in each Region. Rehabilitation professionals will have the option to document, by exception, cases where the PRS does not adequately measure the need of a specific client relative to other clients. The next section describes the PRS Validation Form.

6.2 PRS Validation Form

The PRS Validation Form is designed to be used by rehabilitation professionals to record instances when the PRS score does not accurately represent the level of need of a client relative to other clients. **The form is not intended to be completed for every client.** The PRS Validation Form is designed to collect the following information:

- Client Identification Information
- Service Priority Data
- Validity Data

A copy of the PRS Validation Form is shown in Appendix G. The completed form should be returned to the address on the bottom of the form. Data from this form will be collected until April 30, 1998.

6.3 Formal Evaluation of the PRS

It is anticipated that efforts to establish validity and inter-rater reliability of the PRS will continue after its implementation. Formal inter-rater reliability testing could occur as early as 1998.

6.4 Additional References

A number of documents, textbooks and journal articles were used to facilitate the development of the PRS. A list of helpful references can be found in Appendix H.

Appendix A

Priority Rating Scale Version 1.0



Appendix B

PRS Item Selection Criteria

PRS Item Selection Criteria

- 1- Broad Based - Does this item apply to a broad range of clients?
- 2- Measurable - To what extent can we adequately measure this item?
- 3- Accountable - How comfortable would you be if you had to defend your decision based on this item?
- 4- Important to the Discipline- How important is this item from a discipline perspective?
- 5- Client Centred - Does the item take into consideration the client's perspective?

Appendix C

Discipline Specific Work Group Participants

DISCIPLINE SPECIFIC WORKGROUP PARTICIPANTS/ PARTICIPANTS DES GROUPES DE TRAVAIL PAR DISCIPLINE

November 1996- January 1997

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*Language facilitator

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Appendix D

Field Study Participants

Field Study Participants May-June 1997

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Region 3	Pam Fulton	OT Seniors	York Manor Nursing Home 100 Sunset Drive Fredericton NB E3A 1A3	(tel) 444-3923 (fax) 444-3544
Region 4	Joan Desjardins	PT General population	NB Extra-Mural Program Annexe Brunswick 174, Hébert Boul. Edmundston NB E3V 2S7	(tel) 735-2010 (fax) 735-2514
Region 5	Pauline Perron	OT Pediatrics	Corporation hospitalière de la région 5 C.P. 910, 180 Lily Lake Campbellton NB E3N 3H3	(tel) 789-5544 (fax) 789-5025
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Region 6	José Chenier	OPD General Population	Réseau Santé NOR'EST Health Network 1750 Sunset Drive Bathurst NB E2A 4L7	(tel) 545-1418 (fax) 545-2440
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Appendix E

Additional Information Regarding the PRS

Overview of the Priority Rating Scale (PRS)

What is the Priority Rating Scale?

The PRS is a tool for determining priority for rehabilitation service in a consistent manner across the province. The PRS will help determine which individuals have a greater need for service relative to other individuals.

What priority factors are used in the PRS?

Three primary factors have been identified for consideration in determining the level of priority for rehabilitation service. These factors are applicable to all individual requests for rehabilitation services, regardless of whether the expected service will be in the form of treatment, education or consultation. The factors for determining the relative level of need for service are:

- impact of the primary presenting problem
- predicted outcome of intervention
- impact of service delay

To whom will the PRS apply?

The PRS will be completed on all individuals accepted for service (see Request for Service criteria)

The PRS applies to requests for rehabilitation service directed to the Extra-Mural Program Community Rehabilitation Pools and outpatient rehabilitation services

Group requests and Long Term Care Assessment request will not be prioritized using the Priority Rating Scale. These requests will be managed using the Caseload Management guidelines.

Who completes the PRS?

The PRS is to be completed and signed by a rehabilitation professional. The completed PRS becomes part of the client's health record.

Who completes the PRS for a client who requires multiple rehabilitation service providers?

Each rehabilitation discipline will complete the PRS for clients accepted for service.

When should the PRS be completed?

The PRS must be completed during the Intake process as soon as possible after acceptance of the request for service. The PRS is to be completed at that time using the best available information from a variety of sources.

Who collects information to complete the PRS?

"How" the information is collected and "who" collects the information is to be determined by each unit/department in an effort to ensure the most efficient process. The information can be collected from a variety of sources including, but not limited to, the client, the chart, relevant documentation and/or other sources.

If the client is referred to the same discipline in another service sector, does the PRS score transfer with the client?

The PRS score can be transferred with the client. The decision to accept the transferred PRS score or repeat the PRS is a decision of the receiving rehabilitation professional.

How does the PRS score impact on caseload management?

PRS scores will fall into three levels: High, Medium, and Low. The PRS level will be considered as one of the Caseload Management criteria.

When would it be necessary to repeat the PRS score?

The PRS can be repeated for an individual request prior to intervention if:

there is a reported change in the client's condition
additional information is provided which would significantly alter
the PRS level

What if the rehabilitation professional does not agree with the PRS score?

During the initial implementation of the Rehabilitation Services Plan, there may be exceptional cases when the rehabilitation professional may not agree that the PRS score accurately reflects the client's priority. In those cases, the rehabilitation professional must complete the PRS Validation Form with an explanation as to why the PRS score does not accurately reflect the priority of the client. While the original PRS score cannot change, the rehabilitation professional can provide service to the client using the Caseload Management guidelines.

Appendix F

Priority Rating Scale Scoring Instructions

INSTRUCTIONS FOR SCORING THE PRS

SECTION 1: DESCRIPTIVE INFORMATION

Enter the client's name

Enter the client's date of birth (optional)

Enter the client's medicare number

Enter the discipline of the rehabilitation professional completing the form

Enter the source(s) of information that was used to complete the PRS

Indicate whether the PRS was completed with face-to-face contact with the client or without face-to-face contact with the client (*check one only*)

Enter the anticipated intervention approach for the primary presenting/potential problem (*check one only for the purpose of scoring the PRS*)

Describe in the box below the primary presenting problem or potential problem considering the individual's primary concern

SECTION 2: PRIORITY RATINGS

Rate the global impact of the primary presenting/potential problem on the individual's ability to perform daily living skills (self-care); to contribute to society (productivity) and to enjoy life (leisure).

Enter the number circled on the adjacent rating scale in the box labelled SECTION TOTAL

Rate the individual's potential for benefit from service considering the history and success of previous interventions (if any), previous assessment results (if available); stage in the disease process, research evidence, other health related or "at risk" behaviors, overall health condition and length of time since onset of the presenting problem.

Enter the number circled on the adjacent rating scale in the box labelled SECTION TOTAL

Rate the potential impact of service delay considering: the individual's physical safety; the ability to maximize individual's function and the potential for deterioration in individual's function

Enter the number circled on the adjacent rating scale in the box labelled SECTION TOTAL

SECTION 3: PRIORITY LEVEL

Enter the date that the PRS was completed.

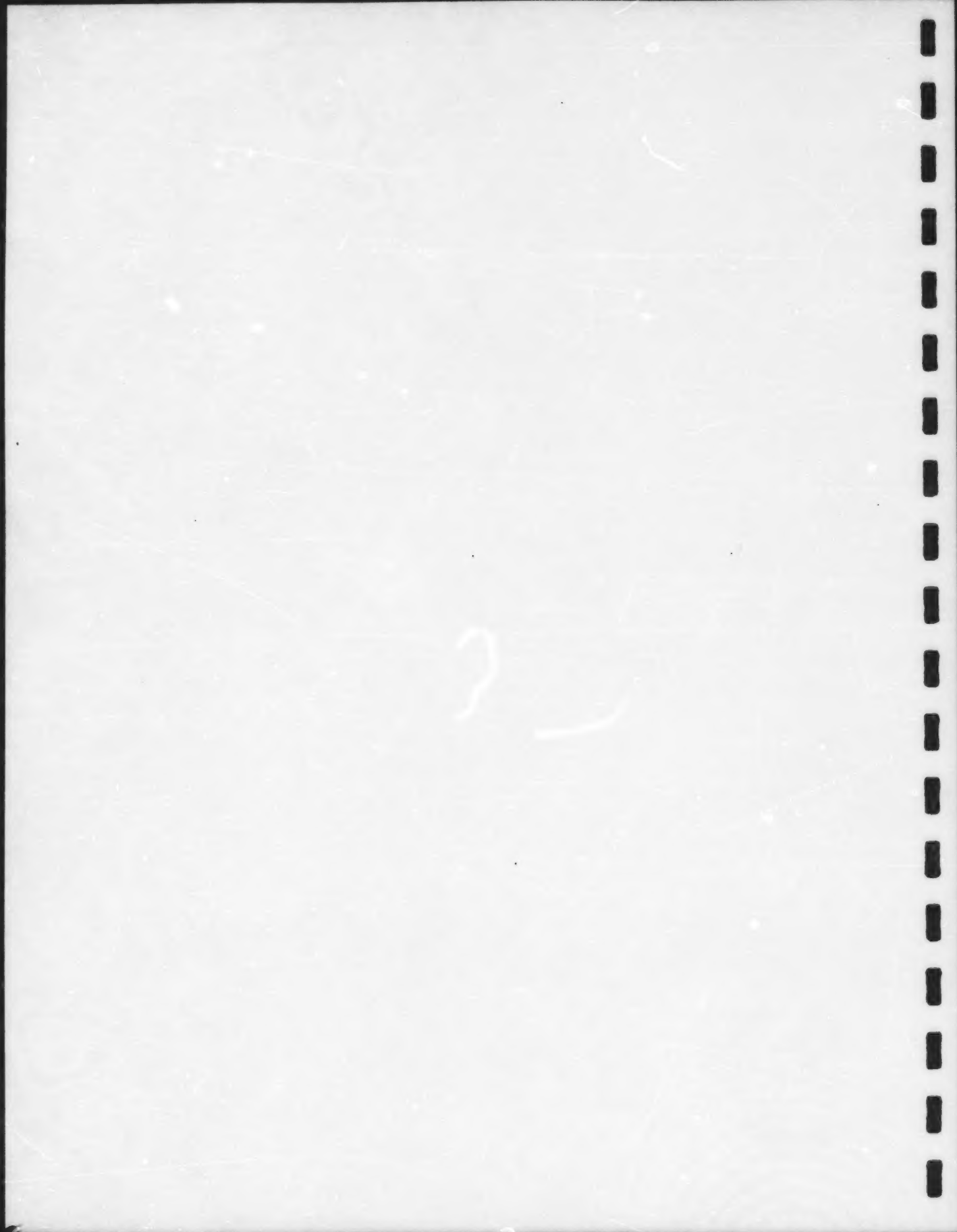
Enter the rehabilitation professional's name or initials who completed the PRS.

Add up the numbers in each of the three 'section total' boxes to calculate the total PRS score.

Place a check mark in the priority level which corresponds with the total PRS score.

**Note: See the User Guide for the PRS for detailed definitions of the priority sub-factors contained within the PRS.*

Appendix G
PRS Validation Form



Appendix H
References for the PRS

References for the PRS

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